Patient Information

Patient Name: _____ Today's Date: _____
Last, First

Birth Date: _____

Health Information

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Reason for today's visit: _____

Are you Allergic to the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Acrylic ☐ Metal ☐ Sulfa Drugs ☐ Local Anesthetic ☐ Other

Women: Are you… ☐ Pregnant - Due Date _____ ☐ Nursing

Have you ever been diagnosed with any of the following; past or currently? Please check all that apply.

☐ AIDS / HIV Positive
☐ Anaphylaxis
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Breathing Problems
☐ Blood Disease
☐ Blood Transfusion
☐ Birth Control
☐ Cancer - Survivor
☐ Casual Drinker
☐ Chemotherapy
☐ Cortisone Medicine
☐ Diabetes-Type 1 or 2
☐ Dizziness
☐ Drug Addiction
☐ Emphysema

☐ Epilepsy
☐ Fainting Spells
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis - A / B / C
☐ Herpes
☐ High Blood Pressure
☐ Hemophilia
☐ Hives/Rash
☐ Hypoglycemia
☐ Jaundice
☐ Kidney Disease
☐ Leukemia

☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pain in Jaw
☐ Parathyroid Disease
☐ Recent Weight Loss
☐ Recreational Drug Use
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sickle Cell Disease
☐ Shingles

☐ Sinus Problems
☐ Smoker/Tobacco
☐ Stomach Problems
☐ Stroke
☐ Swelling in Limbs
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers
☐ Venereal Disease

Other's not listed…
☐ _____
☐ _____
☐ _____
☐ _____

- Have you ever had *any complications following* dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician (medical doctor)? ☐ Yes ☐ No
  If yes, please explain: _____
- Physician's Name: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- **Do you take aspirin daily? ☐ Yes ☐ No** If yes, frequency & dosage _____
- **Are you presently taking any medications for? Please name your medications below with dosage & frequency below.**

☐ Antibiotics ☐ Anticoagulants ☐ Medicine for HBP ☐ Cortisone (Steroids) ☐ Insulin ☐ Herbal supplements
☐ Digitals/Drugs for Heart trouble ☐ Nitroglycerin ☐ Recreational Drugs ☐ Tranquilizers ☐ Over the Counter

_____
_____
_____

In case of emergency, contact: _____ _____

I understand that providing incorrect information can be dangerous for my health, so to the best of my knowledge, all of the information provided is true and correct. **If ever there is any change in my health or medications, I will inform Dr. Fong or his staff at the next appointment without fail.**

_____ Date: _____
Signature of patient, parent or guardian

More on back

Dental Insurance Information

☐ * I have no dental insurance at this time

*** Skip to next section box - - Consent & Financial Policy**

Primary

Name of Cardholder: _____
Last First MI

Employer: _____

Cardholder's Birth Date: _____ ID/SS #: _____ Group #: _____

Patient's relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Cardholder: _____
Last First MI

Employer: _____

Cardholder's Birth Date: _____ ID/SS #: _____ Group #:_____

Patient's relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services & Financial Policy

I consent to the diagnostic procedures and treatment by Dr. Dan Fong and his staff necessary for proper dental health.

Payment for services is due at the time services are rendered along with unpaid deductibles, co-payments and previous balances. We gladly accept cash, personal checks, FHA card, MasterCard / Visa and Discover Card.

As a convenience to you, we will accept assignments of insurance benefits as long as you have complete, up to date insurance information, but copays and deductible still apply and must be paid day treatment is rendered.

Patient balances older than 90 days may be subject to interest charges of 1.5% per month and/or collective action. Returned checks will have an additional fee of $30.00 added to the amount of the returned check.

Confirmations are a courtesy; ultimately it is your responsibility to remember the appointment you scheduled with us.

Any appointment not cancelled or rescheduled at least 48 hours in advance will be charged a late notice fee of $50; 7am & 7:45am appointments carry a late notice fee of $75. The fee must be paid **before** you are seated on your next visit.

I have read the above conditions and I agree to their content; my permission is granted for Dr. Fong and/or his staff to contact me to discuss matters related to my treatment or finances.

Again, thank you for choosing our dental office as your dental health care provider. We appreciate your confidence in us, and the opportunity to serve you.

_____ Date _____ Relationship to Patient _____
(Signature of patient or guardian)

I'm acknowledging that the HIPAA Privacy Act protects my privacy; no dental, medical or financial information will be shared without my permission _____
(Initials please)

** How do you prefer your appointment reminders/confirmations?*
_____ home _____ work _____ cell _____ text _____ e-mail

You are able to confirm your appointment once the text or e-mail arrives.
Make sure the information on first page is complete & accurate.